STATE OF CALIFORNIA

OFFICE OF ADMINISTRATIVE LAW

In re:	**)**	
Request for Regulatory Determination filed by HEALTHDENT OF CALIFORNIA, INC. concerning the method used by the DEPARTMENT OF CORPORATIONS[1] for determining the number of enrollees in Knox-Keene health care service plans	**)**	**2000 OAL Determination No. 5**
	)	**[Docket No. 99-007]**
	)	**February 24, 2000**
	)	**Determination pursuant to Government Code Section 11340.5; Title 1, California Code of Regulations, Chapter 1, Article 3**

Determination by: **DAVID B. JUDSON**
Deputy Director and Chief Counsel

HERBERT F. BOLZ, Supervising Attorney
GEORGE P. RITTER, Senior Staff Attorney
Regulatory Determinations Program

SYNOPSIS

The Office of Administrative Law concludes that the following Department of Corporations policy is a "regulation" which is invalid because it should have been, but was not, adopted pursuant to the Administrative Procedure Act: that for purposes of determining annual fee assessments, a person who is enrolled in one plan and receives services from another plan is deemed to be an "enrollee" of both plans.

DECISION [2, 3, 4, 5, 6]

The Office of Administrative Law ("OAL") has been requested to determine whether a rule claimed to be utilized by the Department of Corporations ("Department") is a "regulation" which must be adopted pursuant to the Administrative Procedure Act ("APA").[7] The challenged rule involves the method the Department purportedly uses or requires to be used in order to ascertain the number of enrollees and subscribers in licensed dental health plans for the purpose of assessing annual fees.

The Office of Administrative Law finds that:

1) The APA is generally applicable to the Department of Corporations;

2) The Department of Corporations has issued, utilized, enforced or attempted to enforce a rule and that rule has general applicability and makes specific the terms of the California Health and Safety Code;

3) No general exceptions to the APA requirements apply to the challenged rule;

4) The rule established by the Commissioner is invalid unless it is adopted as a regulation pursuant to the APA.

REASONS FOR DECISION

I. AGENCY, REQUEST FOR DETERMINATION

The Department of Corporations is responsible for administering a wide range of programs, including the Knox-Keene Health Care Service Plan Act of 1975 ("Knox-Keene Act").[8] That Act provides for the regulation of health care service plans in the State of California. Responsibility for the administration and enforcement of the Knox-Keene Act is vested in the Commissioner of Corporations.[9]

Request for Determination

Healthdent, Inc. is a Knox-Keene health care service plan licensed by the Department of Corporations.[10] In February 1999, E. L. Cruchley, President and CEO of Healthdent, filed a request for determination challenging the method used or required to be used by the Commissioner of Corporations ("Commissioner") in determining the amount of annual assessments to be paid by health care service plans. According to the request, the Commissioner previously had sent Healthdent an invoice for $11,023.46 in assessed fees and also had notified Healthdent that it was in violation of Section 1356 subdivision (b) of the Health and Safety Code.[11] OAL published a summary of this request for determination in the California Regulatory Notice Register, along with a notice inviting public comment. One comment in support of Healthdent's challenge was received from the California Association of Dental Plans ("CADP"). The Department then filed a response to Healthdent's request and CADP's comment. The basis for OAL's determination is set forth below.

II. IS THE APA GENERALLY APPLICABLE TO THE QUASI-LEGISLATIVE ENACTMENTS OF THE DEPARTMENT AND THE COMMISSIONER?

Government Code section 11000 states:

> "As used in this title [Title 2. 'Government of the State of California' (which title encompasses the APA)], 'state agency' includes every state office, officer, *department*, division, bureau, board, and commission. [Emphasis added.]"

The APA narrows the definition of "state agency" from that in section 11000 by specifically excluding "an agency in the judicial or legislative departments of the state government."[12] The Department is in neither the judicial nor legislative branch of state government. Clearly, the Department is a "state agency" within the meaning of the APA.

The chief officer of the Department is the Commissioner.[13] He has been given specific authority to:

> "[A]dopt, amend, and rescind such rules, forms, and orders as are necessary to carry out the provisions of [the Knox-Keene Act]."[14]

The Department has not called our attention to nor have we located any statutory provision expressly exempting rules of the Department or Commissioner from the APA. In addition, rules and regulations adopted by the Commissioner are expressly made subject to the APA. Corporations Code Section 25614 provides in part that:

> "All rules of the commissioner (other than those relating solely to the internal administration of the Department of Corporations) shall be made, amended, or rescinded in accordance with the provisions of the [APA]."

OAL, therefore, concludes that APA rulemaking requirements generally apply to both the Department and the Commissioner.[15]

III. IS THE COMMISSIONER'S METHOD OF COMPUTING ANNUAL ASSESSMENTS A "REGULATION" WITHIN THE MEANING OF GOVERNMENT CODE SECTION 11342?

Government Code section 11342, subdivision (g), defines "regulation" as:

> ". . . *every* rule, regulation, order, or standard of general application *or* the amendment, supplement, or revision of any rule, regulation, order, or standard adopted by *any* state agency to implement, interpret, or make specific the law enforced or administered by it, or to govern its procedure . . . . [Emphasis added.]"

Government Code section 11340.5, authorizing OAL to determine whether agency rules are "regulations," and thus subject to APA adoption requirements, provides in part:

> "(a) *No* state agency shall issue, utilize, enforce, or attempt to enforce *any* guideline, criterion, bulletin, manual, instruction, order, standard of general application, or other rule, which is a [']regulation['] as defined in subdivision (g) of Section 11342, *unless* the guideline, criterion, bulletin, manual, instruction, order, standard of general application or other rule has been adopted as a regulation and filed with the Secretary of State pursuant to [the APA]. [Emphasis added.]"

In *Grier v. Kizer*,[16] the California Court of Appeal upheld OAL's two-part test[17] as to whether a challenged agency rule is a "regulation" as defined in the key provision of Government Code section 11342, subdivision (g):

First, is the challenged rule either:

- a rule or standard of general application, *or*
- modification or supplement to such a rule?

Second, has the challenged rule been adopted by the agency to either:

- implement, interpret, or make specific the law enforced or administered by the agency, *or*
- govern the agency's procedure?

If an uncodified rule satisfies both parts of the two-part test, OAL must conclude that it is a "regulation" subject to the APA. In applying the two-part test, we are mindful of the admonition of the *Grier* court:

> ". . . because the Legislature adopted the APA to give interested persons the opportunity to provide input on proposed regulatory action (*Armistead*, . . . 22 Cal.3d at p. 204, 149 Cal.Rptr. 1, 583 P.2d 744), we are of the view that *any doubt as to the applicability of the APA's requirements should be resolved in favor of the APA.*[18] [Emphasis added.]"

Three California Court of Appeal cases provide additional guidance on the proper approach to take when determining whether an agency rule is subject to the APA.

According to *Engelmann v. State Board of Education* (1991), agencies need not adopt as regulations those rules contained in "a statutory scheme which the Legislature has [already] established . . . ."[19] But "to the extent [that] any of the [agency rules] depart from, or embellish upon, express statutory authorization and language, the [agency] will need to promulgate regulations. . . ."[20]

Similarly, agency rules properly promulgated *as regulations* (i.e., California Code of Regulations ("CCR") provisions) cannot legally be "embellished upon" in administrative bulletins. For example, *Union of American Physicians and Dentists v. Kizer* (1990)[21] held that a terse 24-word definition of "intermediate physician service" in a Medi-Cal regulation could not legally be supplemented by a lengthy seven-paragraph passage in an administrative bulletin that went "far beyond" the text of the duly adopted regulation.[22] Statutes may legally be

amended only through the legislative process; duly adopted regulations—generally speaking—may legally be amended only through the APA rulemaking process.

The third case, *State Water Resources Control Board v. Office of Administrative Law (Bay Planning Commission)* (1993), made clear that reviewing authorities are to focus on the *content* of the challenged agency rule, not the *label* placed on the rule by the agency:

> ". . . [The] Government Code . . . [is] careful to provide OAL authority over regulatory measures whether or not they are designated 'regulations' by the relevant agency. In other words, *if it looks like a regulation, reads like a regulation, and acts like a regulation, it will be treated as a regulation whether or not the agency in question so labeled it*. . . . [Emphasis added.]"[23]

A. DOES THE CHALLENGED ASSESSMENT RULE CONSTITUTE A "STANDARD OF GENERAL APPLICATION"?

For an agency policy to be a "standard of general application," it need not apply to all citizens of the state. It is sufficient if the rule applies to members of a class, kind, or order.[24]

A review of the rule in question clearly indicates that it is a standard of general application. Each licensed Knox-Keene health care service plan operating in the State of California is required to pay an annual assessment or fee to the Commissioner.[25] The purpose of these fees is to reimburse the Commissioner for costs and expenses associated with administration of the Knox-Keene Act.[26] The amount of the fee assessed by the Commissioner is based on the number of enrollees in each licensed health plan.[27] Each plan is required to report the number of its subscribers and enrollees to the Commissioner by a specified date.[28] Healthdent has challenged the underlying assumptions or definitions that the Commissioner has mandated for purposes of determining the number of its subscribers or enrollees.[29]

The requirement for paying an annual assessment or fee applies generally to members of a "class, kind or order." That class would encompass all Knox-Keene health care service plans licensed by the Commissioner.[30] Likewise, the method used to determine the amount of these fees would also apply to this same class.

Alternatively, the Commissioner has imposed standards or procedures which are to be followed by any licensed health care service plan operating under the Knox-Keene Act.[31] Therefore, the Commissioner's method of determining the amount of annual fees to be paid by health care service plans is a standard of general application.

Having concluded that the rule in question is a standard of general application, OAL must consider whether it meets the second prong of the two-part test.

B. DOES THE CHALLENGED METHOD OF DETERMINING THE AMOUNT OF ANNUAL ASSESSMENTS IMPLEMENT, INTERPRET OR MAKE SPECIFIC THE LAW ENFORCED OR ADMINISTERED BY THE DEPARTMENT OR GOVERN ITS PROCEDURE?

1. Background

Health care service plans such as Healthdent are required to pay an annual fee based on the following statutory formula found in Section 1356, subdivision (b), of the Health and Safety Code.

> "Plans offering only specialized health care service plan contracts [i.e vision, dental care, etc.] shall pay seven thousand five hundred dollars ($7,500), plus an amount up to, but not exceeding, an amount computed in accordance with the following schedule:

Plan Enrollment	Amount of Assessment
0 to 25,000	$0 + 48 cents for each enrollee
25,001 to 75,000	$12,000 + 36 cents for each enrollee in excess of 25,000
75,001 to 150,000	$30,000 + 30 cents for each enrollee in excess of 75,000
150,001 to 300,000	$52,500 + 26 cents for each enrollee in excess of 150,000
over 300,000	$91,500 + 24 cents for each enrollee in excess of 300,000."[32]

Through contracts with dental providers, Healthdent arranges for its subscribers and enrollees to receive treatment. In addition, Healthdent operates *its own* dental

facilities. Through these facilities, it provides dental services to enrollees of *other* Knox-Keene health care service plans.[33]

2. The Issue in Dispute

Healthdent does not challenge the underlying requirement that it pay a fee. Rather, it challenges the *amount* it must pay. The crux of this dispute centers on the number of "enrollees" Healthdent is required to include in order to calculate the amount of its fee.

The Commissioner based Healthdent's annual fee assessment on the total number of persons he considered to be enrolled in its plan. That included "*enrollees obtained through contracts with other plans*." [Emphasis added.][34] Healthdent objected to the Commissioner's practice, claiming it to be a "duplicate assessment."[35] Healthdent stated that:

> "[C]ompliance with this previously unknown policy would result in double-counting enrollees of Knox-Keene plans."[36]
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> * * * *
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> "Healthdent is unaware of any general notice, bulletin, newsletter, or formal regulation stating that the Commissioner of Corporations may legally impose an *additional assessment* on a Knox-Keene plan for patients who are subscribers or enrollees of *another Knox-Keene plan* for whom the Commissioner is already being reimbursed." [Emphasis added.][37]

After receiving Healthdent's request for determination, OAL published a Notice of Active Consideration in the California Regulatory Notice Register. As stated, the issue for regulatory determination involved:

> "[I]mposing assessments on a Knox-Keene Plan for subscribers or enrollees of a different Knox-Keene plan who are treated in the assessed Knox-Keene facility, but who are not subscribers or enrollees of the assessed plan."[38] [39]

3. Has the Department Issued, Implemented, Enforced or Attempted to Enforce a "Regulation?"

The Department responded by asserting that it was not imposing a rule, but merely applying an existing statutory requirement by assessing a fee based on the number of enrollees in Healthdent's plan. "[T]he Department only assesses each plan for the plan's enrollees."[40]

The Department, however, seems to have overlooked the impact of its own actions. The Commissioner apparently did not hesitate to levy an annual fee of $11,023.46 on Healthdent based on the number of persons *he considered* to be "enrollees." In order to arrive at this fee, the Commissioner *had to first make a determination concerning the number of people* ***he considered*** *to be "enrollees" of Healthdent.* That number, in turn, had to be counted or calculated by the Commissioner according to some rule, criterion or standard. Based on information contained in the request for determination and the Department's response, it appears that rule, criterion or standard can be articulated as follows.

> "Any licensed health care service plan shall count, or include, as its enrollees those persons:
>
> 1) Who are enrolled in any other health care service plan; and
>
> 2) Whom it treats pursuant to a contract or subcontract made with any other health care service plan."

In addition, Healthdent was apparently told it was in "violation of Section 1356(b)."[41] Thus, the Commissioner not only issued a rule based on *this method of counting enrollees*, but sought to enforce it as well. Nothing in the Department's response remotely suggests that it has abandoned the practice of counting "enrollees" in the manner described by Healthdent and CADP.

The Department also reasons that there is no rule because whatever assessment is made is the *consequence or result* of transactions occurring between various health care plans.

> "If plans are assessed an amount annually under section 1356(b) of the Knox-Keene Act for enrollees who are also enrollees of other plans, this assessment is *the* result *of the plans subcontracting among themselves the obligations of arranging for the provision of health care to enrollees*; it is not because the Department maintains a 'rule' imposing an additional

assessment on plans." [Underscored text in original. Emphasis in italics added by OAL.][42]

* * * *

"The fact that the same person may be the enrollee of multiple 'health care service plans,' . . . is *not the result of a 'state agency rule' . . ., but rather is the* result *of either plans subcontracting among themselves, or employers or individuals subscribing to multiple plans*." [Underscored text in original. Emphasis in italics added by OAL.][43]

OAL disagrees with the Department's characterization of this process. The Commissioner is charged with the responsibility for enforcing the Knox-Keene Act.[44] Part of that responsibility involves the assessment of fees based on the number of "enrollees." Of regulatory necessity, the Commissioner must determine who is an "enrollee" for purposes of assessing these fees under section 1356 of the Health and Safety Code.

The Commissioner has done this. The *basis* for his rule is found in repeated references throughout the Department's response. The rule essentially states that "enrollees" in health care service plans may be "*acquired*" through subcontracts with other plans. That is the "regulation" which interprets, implements or makes specific the term "enrollees" as it is used in the statute.

4. Is the Commissioner's Statutory Interpretation the Only One Which is Legally Tenable?

According to *Engelmann v. State Board of Education* (1991), agencies need not adopt as regulations those rules contained in "a statutory scheme which the Legislature has [already] established . . . ."[45] But "to the extent [that] any of the [agency rules] depart from, or embellish upon, express statutory authorization and language, the [agency] will need to promulgate regulations. . . ."

In a previous determination, we stated:

"If a rule simply applies an *existing* constitutional, statutory or regulatory requirement that has only *one* legally tenable 'interpretation,' that rule is not quasi-legislative in nature – no new 'law' is created."[46]

The Department invokes these principles by claiming that:

> "The procedure followed by the Commissioner to calculate the annual assessment for Healthdent is a *direct application* of Health and Safety Code Section 1356(b)." [Emphasis added.][47]
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> * * * *
>
> "The Department's practice of counting all of the enrollees in a plan in order to determine a plan's annual assessment under Section 1356(b) of the Knox-Keene Act is the only legally tenable interpretation of that section. The statute mandates that the Department assess each plan on a per-enrollee basis, and therefore that is [the] manner that the Department assesses plans. The Department does not make new 'law' by counting all of the enrollees enrolled in the plan."[48]

The Department concludes:

> "Thus, since the Department's annual assessment of plans simply applies the existing statutory requirement that each plan be assessed an amount for *each enrollee*, which has only one legally tenable interpretation, the assessment is not quasi-legislative in nature, no new 'law' is created by the Department, and the APA does not require the adoption of a regulation." [Footnote omitted.][49]

If one were to assume there were no issue concerning the meaning of the term "enrollee," the Department's analysis would be correct. The Department, however, has not focused on the key statutory provision which *defines* that term. Consequently, its analysis essentially begs the fundamental question concerning its application and interpretation of the Knox-Keene Act.

The same logical fallacy exists with the Department's argument that Healthdent is essentially seeking an exemption from the statutory requirements. The Department states in its response that:

> "[T]he statute does not provide an exemption from the assessment provisions . . . for enrollees and subscribers *who are also enrollees and subscribers of other plans.*" [Emphasis added.][50]

Again, the Department takes as a "*given*" the very matter which Healthdent has put in issue. ***Should*** *persons who are treated at other health plans* ***also*** *be considered enrollees or subscribers of those plans?*

The Department declares emphatically that those persons receiving services from Healthdent "*are* [its] enrollees and subscribers."[51] The Department has apparently concluded that its interpretation or application of the term "enrollee" is not at issue. The Department suggested that Healthdent *could not* even raise this as an issue.[52]

The Department states it is merely "counting all the enrollees in every plan."[53] In this context, the statement is circular because the term "enrollees" means anyone so labeled by the Department.

The process of "counting all the enrollees" is clearly mandated by section 1356 of the Health and Safety Code. But who are the "enrollees"? To answer this question, one has to refer to Section 1345, subdivision (c), rather than section 1356.

5. <u>The Definition of the Term "Enrollee"</u>

Health and Safety Code section 1345, subdivision (c), defines "enrollee" to mean:

> "[A] person who is enrolled in a plan *and* who is a recipient of services from *the* plan." [Emphasis added.]

One of the basic canons of statutory interpretation is that "effect must be given, if possible, to every word, clause and sentence of a statute."[54] Therefore, an "enrollee" in a health care service plan would appear to be a person:

a) Who enrolled in the plan; *and*

b) Who received services from *the* plan.[55]

Accordingly, the statutory definition of "enrollee" suggests that the mere receipt of services from a plan is not enough by itself to create enrollment status. In addition to receiving services, the person *also* must be enrolled in the plan. Further, the statute implies that enrollment and receipt of services must come from *the same plan* in order for the person to be deemed an "enrollee." The second part of the

definition refers to receiving services from "*the*" plan. The obvious reference is to the same plan mentioned in the first part of the definition in which the person enrolled.

The fact that the statute includes these two distinct elements appears to be significant for another reason. The concept of enrollment *is distinguished from that of receipt of services*. Thus, one tenable interpretation of the statute would appear to be that receipt of services from a plan does not *by itself* automatically make one an enrollee. This interpretation is significantly different from the Commissioner's policy. Using this interpretation, the Commissioner could have adopted a rule which *would not have included* as a plan's "enrollees" patients from *other plans* who merely received services at the facilities of the plan in question. Thus, OAL disagrees with the Department's argument that its interpretation is the only one possible.

In addition, the Department's "only tenable" interpretation appears to ignore or even obliterate the separate elements necessary for enrollment found in the statute. In doing this, the Department *introduces* the concept of *acquiring enrollees through subcontracts*. Specifically:

> "When plans '*acquire*' enrollees through subcontracts, they also acquire all of the regulatory obligations related to those enrollees, including the annual assessment of Section 1356(b) of the Knox-Keene Act." [Emphasis added.][56]
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> * * * *
>
> "However, Healthdent objects to the *requirement* that it pay an annual assessment for the enrollees *who[m] it has acquired through contracts with other plans*." [Emphasis added.][57]
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> * * * *
>
> "To enable plans to avoid various statutory obligations with respect to enrollees *by acquiring the enrollees through subcontracts with other plans* would frustrate the intent of the Legislature." [Emphasis added.][58]
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> * * * *

> "A determination that subcontracting among plans relieves the plan that is ultimately responsible for care from complying with the consumer protection provisions of the Knox-Keene Act relating to enrollees (by determining that such '*enrollees*' *obtained through subcontracts* are only 'enrollees' of the 'prime' plan and not the subcontractor) defeats the regulatory purposes behind the Knox-Keene Act." [Emphasis added.][59]

The Department also cites the basic structure of Section 1356, subdivision (b), in support of its position. That subdivision contains two separate annual fee schedules. One is for *general* health care service plans, the other for plans offering only "specialized" services. The Department argues that:

> "[S]ection 1356(b) sets forth the assessment requirement based on whether the plan contract is specialized or not, and based on the number of enrollees in each plan. The assessment schedule would not be set forth in this manner if the intent were only to have a single assessment for each person, regardless of the number of plans that the person is enrolled in."[60]

Section 1356, subdivision (b), however, addresses the two basic categories of plans. It is silent about multiple enrollment within those plans. There also is no direct link between the two separate fee schedules in section 1356 for *plans* and fee assessments based on multiple *enrollment* in those plans.

Moreover, section 1356 does not address the circumstances under which multiple enrollments can occur. For instance: Does receipt of treatment in another plan automatically confer enrollment in that plan? Put another way:

> When is a person deemed to be *enrolled* in a health care plan for purposes of fee assessment?

Finally, the Department's assertion that "the assessment provisions of Section 1356(b) . . . were never intended *to ensure* that plans do not have enrollees in common" is somewhat beside the point. [Emphasis added.][61] Commonality of enrollees is not the real issue. Rather, under what circumstances does one *become* an "enrollee?"

Contrary to the Department's assertions, the Knox-Keene Act does not appear to establish enrollment as an involuntary event which automatically occurs when treatment is received in another health care plan. Article 4 of the Knox-Keene

Act, beginning with Section 1359 of the Health and Safety Code is entitled "Solicitation and Enrollment." Section 1363, subdivision (a), provides in part that:

> "The commissioner shall require the use by each plan of disclosure forms or materials containing information regarding the benefits, services, and terms of the plan contract as the commissioner may require, so as to afford the public, subscribers, and enrollees with a full and fair disclosure of the provisions of the plan in readily understood language and in a clearly organized manner."

In many circumstances, enrollment also appears to involve a contractual relationship between the subscriber or enrollee. The Knox-Keene Act defines the term "plan contract" to mean:

> "[A] contract between a plan and its subscribers or enrollees or a person contracting on their behalf pursuant to which health care services, including basic health care services, are furnished . . . ."[62]

The Knox-Keene Act also confers upon the enrollee or subscriber certain vested rights.[63] If the plan cancels an enrollment because of the enrollee's health status, the enrollee may request a hearing.[64]

> "If, after hearing, the commissioner determines that the cancellation or failure to renew is contrary [to certain statutory provisions], the commissioner shall order the plan to reinstate the enrollee or subscriber. A reinstatement pursuant to this subdivision shall be retroactive to the time of cancellation or failure to renew and the plan shall be liable for the expenses incurred by the subscriber or enrollee for covered health care services from the date of cancellation or nonrenewal to and including the date of reinstatement."[65]

In light of these provisions, one might suspect that the average subscriber or enrollee would have some fundamental differences with the Commissioner over the ramifications of his current policy concerning enrollment status. For instance, consider a situation involving an enrollee in Plan A who is referred for treatment at facilities operated by Plan B. How would that person react if told that as a consequence of this treatment he or she would then be considered to be enrolled in Plan B *as well as* Plan A?

For the sake of comparison, assume the statutory definition of "enrollee" were expanded using bold, italicized language as follows:

> "As used in this chapter: . . . . 'Enrollee' means:
>
> A person who is enrolled in a plan and who is a recipient of services from the plan. ***A person who is enrolled in one plan and who receives services from any other plan is deemed to be an enrollee of both plans***."

If this type of statutory definition actually existed, then the position taken by the Department would be legally sound. There would be no reason to adopt a regulation implementing its current method of counting "enrollees." The Department would be directly applying a statutory definition in determining the number of enrollees in each plan. This would be the tantamount to a ministerial act. Under those circumstances, the Commissioner's current policy would indeed be the "only tenable" interpretation of the statute.

The emphasized language quoted above is obviously not in the statute. But the actions taken by the Commissioner have the effect of *adding* this language. This is a classic example of a "regulation" which is subject to the APA. Government Code section 11342, subdivision (g), provides in part that a "regulation" means:

> [E]very rule, regulation, order, or standard of general application *or the amendment, supplement, or revision* of any rule, regulation, order, or standard adopted by any state agency to *implement, interpret, or make specific* the law enforced or administered by it . . . ." [Emphasis added.]

Under this basic authority, the Commissioner's policy requiring Knox-Keene Health plans to include as "enrollees" patients whom they treat but who are enrolled in another plan, is clearly a "regulation" which is subject to the APA.[66]

IV. DO THE CHALLENGED DIRECTIVES FOUND TO BE "REGULATIONS" FALL WITHIN ANY RECOGNIZED EXEMPTION FROM APA REQUIREMENTS?

Generally, all "regulations" issued by state agencies are required to be adopted pursuant to the APA, unless *expressly*[67] exempted by statute.[68] In *United Systems of Arkansas v. Stamison* (1998),[69] the California Court of Appeal rejected an argument by the Director of the Department of General Services that language in

the Public Contract Code had the effect of impliedly exempting rules governing bid protests from the APA.

According to the *Stamison* Court:

> *"When the Legislature has intended to exempt regulations from the APA, it has done so by clear, unequivocal language.* (See, e.g., Gov. Code, section 16487 ['The State Controller may establish procedures for the purpose of carrying out the purposes set forth in Section 16485. These procedures are exempt from the Administrative Procedure Act.']; Gov. Code, section 18211 ['Regulations adopted by the State Personnel Board are exempt from the Administrative Procedure Act']; Labor Code, section 1185 [orders of Industrial Welfare Commission 'expressly exempted' from the APA].) [Emphasis added.]"[70]

Express statutory APA exemptions may be divided into two categories: special and general.[71] *Special* express statutory exemptions typically: (1) apply only to a portion of one agency's "regulations" and (2) are found in that agency's enabling act. *General* express statutory exemptions typically: (1) apply across the board to all state agencies and (2) are found in the APA. An example of a *special* express exemption is Penal Code section 5058, subdivision (d)(1), which exempts pilot programs of the Department of Corrections under specified conditions. An example of a *general* express exemption is Government Code section 11342, subdivision (g), part of which exempts "internal management" regulations of all state agencies from the APA.

A. DO THE CHALLENGED DIRECTIVES FALL WITHIN ANY *SPECIAL* EXPRESS APA EXEMPTION?

The Department does not contend that any special statutory exemption applies. Our independent research having also disclosed no special statutory exemption, we conclude that none applies.

B. DO THE CHALLENGED DIRECTIVES FALL WITHIN ANY *GENERAL* EXPRESS APA EXEMPTION?

The Department does not contend that any general express exemption applies. Our independent research having also disclosed no general express statutory exemption, we conclude that none applies.

Since the challenged rule does not falls within any express statutory exemption from the APA, OAL concludes that it is without legal effect because it has not been adopted in compliance with the APA.

CONCLUSION

For the reasons set forth above, OAL finds that:

1. The APA is generally applicable to the Commissioner and the Department.

2. The Commissioner has issued, utilized, enforced or attempted to enforce the challenged rule.

3. The challenged rule is one of general applicability and makes specific the terms of the Knox-Keene Act.

4. No general exceptions to the APA requirements apply to the Commissioner's rule.

5. The rule established by the Commissioner is invalid unless it is adopted as a regulation pursuant to the APA.

DATE: February 24, 2000

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ENDNOTES

1. This request for determination was filed by E. L. Cruchley, President & CEO of Healthdent, Inc., 2848 Arden Way, Suite 100 Sacramento, Ca. 95825, (916) 486-0749. The Department of Corporations responded to the request and was represented by William Kenefick, Acting Commissioner of Corporations; Timothy L. LeBas, Senior Corporations Counsel; Colleen E. Monahan, Corporations Counsel; Rebecca Ruggero, Corporations Counsel; Joyce Vermeersch, Corporations Counsel, 980 Ninth Street, Suite 500, Sacramento, Ca. 95814-2724, (916) 445-7205.

2. This determination may be cited as "**2000 OAL Determination No. 5.**"

   Pursuant to Title 1, CCR, section 127, this determination becomes effective on the 30th day after filing with the Secretary of State, which filing occurred on the date shown on the first page of this determination.

   Government Code section 11340.5, subdivision (d), provides that:

   > "Any interested person may obtain judicial review of a given determination by filing a written petition requesting that the determination of the office be modified or set aside. A petition shall be filed with the court within 30 days of the date the determination is published [in the California Regulatory Notice Register]."

   Determinations are ordinarily published in the Notice Register within two weeks of the date of filing with the Secretary of State.

3. If an uncodified agency rule is found to violate Government Code section 11340.5, subdivision (a), the rule in question may be validated by formal adoption "as a *regulation*" (Government Code section 11340.5, subd. (b); emphasis added) or by incorporation in a statutory or constitutional provision. See also *California Coastal Commission v. Quanta Investment Corporation* (1980) 113 Cal.App.3d 579, 170 Cal.Rptr. 263 (appellate court authoritatively construed statute, validating challenged agency interpretation of statute.) An agency rule found to violate the APA could also simply be rescinded.

4. OAL does not review alleged underground regulations for compliance with the APA's six substantive standards of Necessity, Authority, Clarity, Consistency, Reference, and Nonduplication. However, in the event regulations were proposed by the Department under the APA, OAL would review the *proposed* regulations for compliance with the six statutory criteria. (Government Code sections 11349 and 11349.1.)

5. Title 1, California Code of Regulations ("CCR") (formerly known as the "California Administrative Code"), subsection 121 (a), provides:

" '*Determination*' means a finding by OAL as to whether a state agency rule is a 'regulation,' as defined in Government Code section 11342(g), which is *invalid and unenforceable* unless

> (1) it has been adopted as a regulation and filed with the Secretary of State pursuant to the APA, or,
>
> (2) it has been exempted by statute from the requirements of the APA. [Emphasis added.]"

See *Grier v. Kizer* (1990) 219 Cal.App.3d 422, 268 Cal.Rptr. 244, review denied (finding that Department of Health Services' audit method was *invalid* because it was an underground regulation which should be adopted pursuant to the APA); and *Planned Parenthood Affiliates of California v. Swoap* (1985) 173 Cal.App.3d 1187, 1195, n. 11, 219 Cal.Rptr. 664, 673, n. 11 (citing Gov. Code sec. 11347.5 (now 11340.5) in support of finding that uncodified agency rule which constituted a "regulation" under Gov. Code sec. 11342, subd. (b)—now subd. (g)—yet had not been adopted pursuant to the APA, was "*invalid*"). We note that a l996 California Supreme Court case stated that it "disapproved" of *Grier* in part. *Tidewater Marine Western, Inc. v. Bradshaw* (l996) 14 Cal.4th 557, 577, 59 Cal.Rptr. 2d 186, 198. *Grier*, however, is still authoritative, except as specified by the *Tidewater* court. *Tidewater* itself, in discussing which agency rules are subject to the APA, referred to "the two-part test of the Office of Administrative Law," citing *Union of American Physicians & Dentists v. Kizer* (1990) 223 Cal.App.3d 490, 497, 272 Cal.Rptr. 886, a case which quotes the test from *Grier v. Kizer.*

6. *OAL Determinations Entitled to Great Weight in Court*

The California Court of Appeal has held that a statistical extrapolation rule utilized by the Department of Health Services in Medi-Cal audits must be adopted pursuant to the APA. *Grier v. Kizer* (1990) 219 Cal.App.3d 422, 268 Cal.Rptr. 244, disapproved on other grounds in *Tidewater*. Prior to this court decision, OAL had been requested to determine whether or not this Medi-Cal audit rule met the definition of "regulation" as found in Government Code section 11342, subdivision (b) (now subd. (g)), and therefore was required to be adopted pursuant to the APA. Pursuant to Government Code section 11347.5 (now 11340.5), OAL issued a determination concluding that the audit rule met the definition of "regulation," and therefore was subject to APA requirements. **1987 OAL Determination No. 10**, CRNR 96, No. 8-Z, February 23, 1996, p. 293. The *Grier* court concurred with OAL's conclusion, stating that:

> "Review of [the trial court's] decision is a question of law for this court's independent determination, namely, whether the Department's use of an audit method based on probability sampling and statistical extrapolation constitutes a regulation within the meaning of section 11342, subdivision (b) [now subd. (g)]. [Citations.]" (219 Cal.App.3d at p. 434, 268 Cal.Rptr. at p. 251.)

Concerning the treatment of **1987 OAL Determination No. 10**, which was submitted for its consideration in the case, the court further found:

> "While the issue ultimately is one of law for this court, 'the contemporaneous administrative construction of [a statute] by those charged with its enforcement and interpretation is *entitled to great weight*, and courts generally will not depart from such construction unless it is clearly erroneous or unauthorized. [Citations.]' [Citations.] [Par.] Because [Government Code] section 11347.5, [now 11340.5] subdivision (b), charges the OAL with interpreting whether an agency rule is a regulation as defined in [Government Code] section 11342, subdivision (b) [now subd. (g)], *we accord its determination due consideration*.[*Id*.; emphasis added.]"

See also *Union of American Physicians & Dentists v. Kizer* (l990) 223 Cal.App.3d 490, 497, 272 Cal.Rptr. 886 (same holding) and note 5 of **1990 OAL Determination No. 4,** California Regulatory Notice Register 90, No. 10-Z, March 9, 1990, p. 384, at p. 391 (reasons for according due deference consideration to OAL determinations).

7. According to Government Code section 11370:

> "*Chapter 3.5* (commencing with Section 11340), *Chapter 4* (commencing with Section 11370), *Chapter 4.5* (commencing with Section 11400, and *Chapter 5* (commencing with Section 11500) *constitute*, and may be cited as, *the Administrative Procedure Act*. [Emphasis added.]"

OAL refers to the portion of the APA which concerns rulemaking by state agencies: Chapter 3.5 of Part 1 ("Administrative Regulations and Rulemaking") of Division 3 of Title 2 of the Government Code, sections 11340 through 11359.

8. The following are examples of some of the other Acts administered by the Department of Corporations: "Corporate Securities Law of 1968" (Corporations Code Section 25000 et seq.); "Bucket Shop Law" (Corporations Code Section 29000 et seq.); "Check Sellers, Bill Payers and Proraters Law" (Financial Code Section 12000 et seq.); "California Finance Lenders Law" (Finance Code Section 22000 et seq.); "Escrow Law" (Financial Code Section 17000 et seq.); "Securities Depository Law" (Financial Code Section 30000 et seq.).

9. Health and Safety Code section 1341. A statute enacted in 1999 will transfer the responsibility for regulating the Knox-Keene Health Care Service Plan Act from the Commissioner of Corporations to the Director of the newly created Department of Managed Care. Stats. 1999, Ch. 525, Sections 1 and 2.

10. Request for Determination, dated February 1, 1999, p. 1.

11. *Id*. at 2. It appears from Healthdent's request for determination that the Commissioner's

current method for ascertaining the number of "enrollees" in a plan may be of fairly recent origin. Healthdent indicates that it has been a licensed plan since 1983. In June 1997, it was notified that "the annual assessments depend[ed] not only on the number of Healthdent enrollees . . . but also on the number of patients treated in Healthdent's plan-owned and operated dental facilities who were enrollees of other Knox-Keene heath care service plans." *Id*. at 1. Healthdent also referred to this as a "previously unknown policy." *Id*. In addition, the California Association of Dental Plans ("CADP") stated in its comment that "the California State Auditor concluded that for the past several years, health plans have been substantially overcharged by the Department." Comment of CADP, dated Dec. 8, 1999, p. 2.

12. Government Code section 11342, subdivision (a).

13. Corporations Code section 25600.

14. Health & Safety Code sections 1344.

15. See *Winzler & Kelly v. Department of Industrial Relations* (1981) 121 Cal.App.3d 120, 126-128, 175 Cal.Rptr. 744, 746-747 (unless "expressly" or "specifically" exempted, all state agencies not in legislative or judicial branch must comply with rulemaking part of the APA when engaged in quasi-legislative activities); *Poschman v. Dumke* (1973) 31 Cal.App.3d 932, 942, 107 Cal.Rptr. 596, 603 (agency created by Legislature is subject to and must comply with APA).

16. (1990) 219 Cal.App.3d 422, 440, 268 Cal.Rptr. 244, 251. OAL notes that a l996 California Supreme Court case stated that it "disapproved" of Grier in part. *Tidewater Marine Western, Inc. v. Bradshaw* (l996) 14 Cal.4th 557, 577. Grier, however, is still good law, except as specified by the *Tidewater* court. Courts may cite cases which have been disapproved on other grounds. For instance, in *Doe v. Wilson* (l997) 57 Cal.App.4th 296, 67 Cal.Rptr.2d 187, 197, the California Court of Appeal, First District, Division 5 cited *Poschman v. Dumke* (l973) 31 Cal.App.3d 932, 107 Cal.Rptr. 596, on one point, even though *Poschman* had been expressly disapproved on another point nineteen years earlier by the California Supreme Court in *Armistead v. State Personnel Board* (1978) 22 Cal.3d 198, 204 n. 3, 149 Cal.Rptr. 1, 3 n. 3. Similarly, in *Economic Empowerment Foundation v. Quackenbush* (l997) 57 Cal.App.4th 677, 67 Cal.Rptr.2d 323, 332, the California Court of Appeal, First District, Division 4, nine months after *Tidewater*, cited *Grier v. Kizer* as a distinguishable case on the issue of the futility exception to the exhaustion of administrative remedies requirement.

    *Tidewate*r itself, in discussing which agency rules are subject to the APA, referred to "the two-part test of the Office of Administrative Law," citing *Union of American Physicians & Dentists v. Kizer* (l990) 223 Cal.App.3d 490, 497, 272 Cal.Rptr. 886, a case which quotes the test from *Grier v. Kizer*

17. The *Grier* Court stated:

> "The OAL's analysis set forth a two-part test: 'First, is the informal rule either a rule or standard of general application or a modification or supplement to such a rule? [Para.] Second, does the informal rule either implement, interpret, or make specific the law enforced by the agency or govern the agency's procedure?' (1987 OAL Determination No. 10, . . . slip op'n., at p. 8.) [*Grier*, disapproved on other grounds in *Tidewater*]."

OAL's wording of the two-part test, drawn from Government Code section 11342, has been modified slightly over the years. The cited OAL opinion—**1987 OAL Determination No. 10**—was published in California Regulatory Notice Register 96, No. 8-Z, February 23, 1996, p. 292.

18. (1990) 219 Cal.App.3d 422, 438, 268 Cal.Rptr. 244, 253. The same point is made in *United Systems of Arkansas v. Stamison* (l998) 63 Cal.App.4th 1001,1010, 74 Cal.Rptr.2d 407, 412, review denied.

19. 2 Cal.App.4th 47, 62, 3 Cal.Rptr. 886, 891.

20. *Id.*

21. 223 Cal.App.3d 490, 501, 272 Cal.Rptr. 886, 891.

22. *Id.*

23. (1993) 12 Cal.App.4th 697, 702, 12 Cal.Rptr.2d 25, 28.

24. *Roth v. Department of Veteran Affairs* (1980) 110 Cal.App.3d 622, 167 Cal.Rptr. 552. See *Faulkner v. California Toll Bridge Authority* (1953) 40 Cal.2d 317, 323-324 (standard of general application applies to all members of any open class).

25. Health and Safety Code section 1356 subdivision (b).

26. *Id*.

27. *Id*.

28. Title 10, CCR, section 1300.84.6.

29. Request for Determination, dated February 1, 1999, p. 2.

30. Health and Safety Code sections 1343; 1345, subdivision (f); 1356, subdivision (b).

31. Evidence of general application is also found in the Department's response. "[T]he Department only assesses each plan for the plan's enrollees." Response, p. 3. "In

determining the assessment amounts for each plan under Section 1356(b) of the Knox-Keene Act, the Department counts all the enrollees in each plan as provided in the statute." Id. at 6.

32. Health and Safety Code section 1356, subdivision (b). In 1999, the Legislature signaled its intent "to transfer the administration of the Knox-Keene Health Care Service Plan Act from the Commissioner of Corporations of the Department of Corporations to the Director of the Department of Managed Care established in the Business, Transportation and Housing Agency." (Stats. 1999 Ch. 525 section 1.) This transfer is to become "operative on the date that the Governor, by executive order, establishes the Department of Managed Care or July 1, 2000, whichever occurs first." (Stats. 1999 Ch. 525 section 14.) For that reason, numerous provisions of the Act codified in the Health and Safety Code are written in duplicate with one set of code sections pertaining to the "commissioner" and the other to the "director."

33. Request for Determination, dated Feb. 1, 1999, p. 1.

34. Department of Corporations Response to Request for Determination, dated Dec. 27, 1999, p. 3.

35. Request for Determination, p. 2.

36. Id. at 1.

37. Id. at 2.

38. California Regulatory Notice Register 99, No. 46-Z, Nov. 12, 1999, p. 2216.

39. The Department strongly objected to OAL's characterization of this issue. It stated in its response that:

> "This statement of the issue for determination by the OAL assumes a fact (and thereby reaches a legal conclusion) that was not included in the requesting party's Request for Determination. Specifically, . . . Healthdent states that the Department imposes 'an additional assessment on a Knox Keene plan for patients who are subscribers or enrollees of another Knox Keene plan for whom the Commissioner is already being reimbursed.' Healthdent does not state that the Department imposes assessments on a Knox Keene plan for subscribers or enrollees 'who are not subscribers or enrollees of the assessed plan.' However, the OAL makes precisely this assertion in its statement of the issue for determination." Response to Request for Determination, p. 2.

The Department also apparently implied that it is impossible to even characterize the issue in this way.

> "Healthdent does not assert that the enrollees of other plans *are not also enrollees of Healthdent*. Healthdent *cannot* make this assertion . . . ." [Emphasis added.] *Id.* at 7.

The Department appears to be taking the position that the question of who are Healthdent's enrollees is not open for discussion. Further, it accuses OAL of "exceed[ing] its authority by inappropriately interpreting the legal definitions of what constitutes 'subscribers' or 'enrollees' of a health care service plan." *Id.* at 2.

The Department's objection is based in part on what is roughly equivalent to a distinction without any appreciable difference. Healthdent clearly has no problems paying a fee based on the number of enrollees in *its* plan. Healthdent, however, takes the position that the Commissioner's policy is in "contravention of the plain language of the statute." Request for Determination, p. 1. It questions whether the Commissioner has the authority to include enrollees from "*another* Knox-Keene plan." [Emphasis added.] *Id.* at 2. The implication from this statement is that Healthdent does *not* consider enrollees of "another" plan to be its "enrollees" for purposes of assessing annual fees. If it did, then its current regulatory challenge would seem to be pointless. It would be tantamount to admitting the following:

> "Healthdent recognizes that patients it treats who are enrolled in another Knox-Keene plan are also enrolled in Healthdent."

Nothing in its regulatory challenge even remotely suggests that Healthdent accepts this concept.

In addition, comments submitted by the California Association of Dental Plans ("CADP") strongly suggest that the Department is in the minority regarding how the issue should be framed. CADP writes:

> "The Department of Corporations assessed Dental Plan A, B, etc., for their enrollees, and subsequently assessed Healthdent for those same enrollees (of Dental Plan A, B, etc.) for whom it provided contracted services. Because the language in Health and Safety Code Section 1356(b) is clear, CADP asserts that the Department does not have the regulatory authority to impose an assessment on a dental plan for *subscribers or enrollees of a different dental plan who are treated in the assessed facility's provider offices but who are not subscribers or enrollees of the assessed plan*, that it results in an overassessment of the plan, and that the Department receives a duplicate assessment for the same enrollee." [Emphasis added.] Letter of CADP, dated Dec. 8, 1999, p. 1.

Contrary to the Department's assertions, OAL was not reaching a *legal* conclusion when it framed the issue in terms of patients *not* being enrolled in Healthdent. There is clearly

a fundamental difference regarding the *original source* of patients Healthdent treats as opposed to how they are classified *once* they are treated. Nor did OAL conclude that *as a matter of law these patients cannot be considered to be enrolled in Healthdent after having been treated at its facilities.*

In addition, the manner in which the requester frames the issue is not necessarily conclusive for purposes of determining what issue OAL will address. Nor does it somehow limit OAL's authority as the Department seems to imply. Government Code section 11340.5, subdivision (b) provides that:

> "If [OAL] is notified of, or on its own, learns of the issuance, enforcement of, or use of, an agency guideline, criterion, bulletin, manual, instruction, order, standard of general application, or other rule that has not been adopted as a regulation and filed with the Secretary of State pursuant to this chapter, the office may issue a determination as to whether the guideline, criterion, bulletin, manual, instruction, order, standard of general application, or other rule, is a regulation as defined in subdivision (g) of Section 11342." [Emphasis added.]

Therefore, even if OAL articulated the challenged rule in a way which differed from the manner in which it was described by Healthdent, this would be permissible under Section 11340.5. The determination of whether this rule is a "regulation" subject to the APA should also be contrasted with the issue of whether the Commissioner *could* adopt such a regulation consistent with statutory authority. The latter issue is not the focus of this regulatory determination. That is a consistency issue. (OAL does make such determinations in the case of proposed regulations being submitted for adoption. Government Code sections 11349; 11349.1.)

Moreover, OAL has been empowered by the Legislature to issue regulatory determinations. Government Code section 11340.5, subdivision (b). Once it accepts a request challenging an agency rule, it is under a *legal duty* to go forward and issue a determination as to whether the rule is a "regulation" subject to the APA. Title 1, CCR, sections 123 – 126. That mandated procedure is the one OAL is following with respect to the regulatory challenge initiated by Healthdent.

40. Response, p. 3.

41. Request for Determination, p. 2.

42. Response, p. 3.

43. *Id*. at 11.

44. Health and Safety Code section 1341.

45. 2 Cal.App.4th 47, 62, 3 Cal.Rptr. 886, 891.

46. **1986 OAL Determination No. 4** (Board of Equalization, June 25, 1986, Docket No. 85-005) California Administrative Notice Register 86, No. 28-Z, July 11, 1986, p. B-15, typewritten version, p. 12.

47. Response, p. 13.

48. *Id*. at 3, 12.

49. *Id*.

50. *Id*. at 17.

51. *Id*. at 19.

52. The Department states in its response that:

> "Healthdent does not assert that the enrollees of other plans are not also enrollees of Healthdent. Healthdent *cannot* make this assertion for two reasons: First, Healthdent is operating as a plan with respect to these enrollees by arranging for the provision of care in exchange for a prepaid or periodic charge. [Footnote omitted.] Second, Healthdent must be a plan under California law to be licensed to operate under the structure it has chosen, because the Business and Professions Code limits the number of dental offices that a licensed dentist may maintain, and a dentist must be in personal attendance at each of his or her place[s] of practice at least 50 percent of the time during which such places of practice are open for the practice of dentistry." Response, pp. 7 – 8. [Emphasis added. Footnotes omitted.]

53. *Id*. at 12.

54. 2A Sutherland, *Statutory Construction* (5th Ed. 1993), Section 46.06, p. 119; *Rodriguez v. Superior Court* (1993) 14 Cal.App.4th 1260, 1269, 18 Cal.Rptr.2d 126.

55. There is one hypothetical issue which could be argued with respect to the definition of "enrollee" found in Health and Safety Code section 1345, subdivision (c). Under this section, an "enrollee" must be enrolled in a plan *and* also receive services from the plan. If a person enrolled in a plan, but was referred for treatment at another plan, then it is theoretically possible to argue that this person would not meet the statutory definition of an "enrollee." One obvious rejoinder to such an argument would be that the person's plan is still "providing" services, but doing so through a third party. This issue, however, was not raised by any of the parties. The underlying assumption appeared to be that patients being treated were "enrollees" of *some* plan. The issue raised by both Healthdent

and CADP centered on whether a person enrolled at one plan, but treated at another, should be counted as an "enrollee" of *both*. Moreover, even if it were possible to construct such a legal scenario, it would not change the results of this determination. At a minimum, the Commissioner would still be required to adopt a regulation pursuant to the APA in order to clarify the legal status of such persons as either "enrollees" or "non-enrollees."

56. Response, p. 3.

57. *Id*. at 7.

58. *Id*. at 14.

59. *Id*. at 15.

60. *Id*. at 11.

61. *Id*. at 19.

62. Health and Safety Code section 1345, subdivision (r).

63. Health and Safety Code section 1365, subdivision (a).

64. Health and Safety Code section 1365, subdivision (b).

65. *Id*.

66. In its response, the Department presents the equivalent of a regulatory conundrum concerning the regulation of "providers" of dental services. To understand this issue, some discussion of the interplay between the Knox-Keene Act and the regulation of dentists in the State of California is necessary.

Dentists and providers of dental services are regulated under the Dental Practice Act. Business and Professions Code section 1600 et seq. One of the provisions of that act prohibits dentists from practicing at more than one location unless the dentist is in personal attendance at each place of business more than fifty percent (50%) of the time. Business and Professions Code section 1658.1.

According to the Department, health care service plans it licenses under the Knox-Keene Act are not subject to this restriction. It notes that:

> "In the instant case, Healthdent is not organized as a professional corporation under 13400 et seq. of the Corporations Code. Healthdent operates as a 'health care service plan' licensed by the Commissioner. Therefore, Healthdent may

> legally operate many dental offices without the 'owner' dentist(s) being present at each office at least 50 percent of the time, because Section 1395(b) of the Knox-Keene Act specifically states that plans shall not be deemed to be engaged in the practice of a profession. Further, Healthdent's shareholders may be persons who are not licensed professionals." Response pp. 16 - 17.

The Department reasons that if Healthdent is treating or providing services to patients who *are not its "enrollees,"* then it would presumably be in violation of the Dental Practice Act. Specifically, Healthdent would no longer be acting as a "plan," but rather as a "provider" of dental services and then be subject to, among other things, the 50% attendance limitation of the Business and Professions Code. With 11 different locations, Healthdent presumably could not meet this requirement. *Id*. Therefore, the Department has concluded that:

> "Healthdent does not have the legal capacity to be just a 'provider' for the enrollees it obtains through contracts with other plans." *Id*. at 17.

Because Healthdent cannot be considered a "provider," the inexorable conclusion the Department reaches is that anyone whom it treats *must be* an "enrollee." According to the Department, Healthdent "*cannot*" make the assertion "that the enrollees of other plans are not also enrollees of Healthdent." [Emphasis added.] *Id*. at 7.

There are several problems with the Department's reasoning. First, a person can actually perform an act even though he or she lacks legal capacity to do so. Classic examples include a ten year-old driving a car on a public highway or a teenager purchasing alcoholic beverages. Similarly, assume for the sake of discussion that Healthdent cannot *legally* treat persons who are not its enrollees. That does not mean Healthdent cannot *in fact* do so.

The fallacy of the Department's logic becomes apparent if Healthdent were, for instance, to treat anyone at its facilities who walked in off the street. That could very well be a violation of the Knox-Keene Act, the Dental Practice Act, or both. But could the Department say these patients who walked in off the street were "*enrollees*" of Healthdent? Put another way, the fact that a regulated entity may not have the legal capacity to do something does not mean the opposite automatically becomes law.

In the same vein, the Department does not have the "legal capacity" to issue or enforce regulations unless they have been adopted pursuant to the APA. Government Code section 11340.5. Does that mean *it cannot in fact do so*? Clearly that is not the case. State agencies frequently utilize "underground regulations" which have no *legal* force and effect. OAL would certainly be remiss if it then concluded as a matter of law all of these underground regulations had to be legitimate or else the particular agencies would be in violation of the law. Similarly, if Healthdent is operating in violation of the law by

providing treatment to "non-enrollees," the solution is not to issue an underground regulation. The solution is for either the Commissioner or the Board of Dental Examiners to take appropriate disciplinary action.

OAL has found no provision of the Health and Safety Code that equates treatment as the *legal equivalent* of "enrollment." The Department, of course, is free to adopt a regulation consistent with existing statutory law in order to address the problem it perceives with Healthdent's status as either a "provider" or a "plan." But that rationale, however, cannot by itself serve as the legal basis for issuing, enforcing, or attempting to enforce such a "regulation" without complying with the procedures found in the APA.

Contrary to the Department's assertion, OAL makes no such "finding of fact" with respect to whether or not Healthdent is a "provider." See Response, p. 19. That is an issue for either the Department or the Board of Dental Examiners. The Department seems to imply by its accusation that OAL or anyone else who questions its definition of the term "enrollee" is perforce making a factual finding about the legal status of Healthdent. The two are not the same. OAL must determine whether the Department's interpretation or enforcement of the term "enrollee" is a "regulation" subject to the APA. That is purely a legal issue which is independent of whatever factual circumstances may exist with respect to Healthdent.

The Department also raised the following public policy concerns in support of its current policy:

1) The need to provide protection for "enrollees;"

2) Consumer protection; and

3) The level of fee reimbursement the Department needs in order to regulate health care service plans. *Id*. at 15 – 18.

All of these are legitimate regulatory concerns. The place they should be addressed, however, is in a Statement of Reasons demonstrating to the public the need for whatever regulations the Department deems are necessary and appropriate to implement, interpret, and administer the Knox-Keene Act.

67. The following agency enactments, among others, have been expressly exempted by statute:

a. Rules relating *only* to the internal management of the state agency. (Gov. Code, sec. 11342, subd. (g).)

b. Forms prescribed by a state agency or any instructions relating to the use of the form, *except* where a regulation is required to implement the law under which the form is issued. (Gov. Code, sec.11342, subd. (g).)

c. Rules that "[establish] or [fix], *rates, prices, or tariffs*." (Gov. Code, sec. 11343, subd. (a)(1); emphasis added.)

d. Rules directed to a *specifically named* person or group of persons *and* which do not apply generally throughout the state. (Gov. Code, sec. 11343, subd. (a)(3).)

e. Legal rulings *of counsel* issued by the Franchise Tax Board or the State Board of Equalization. (Gov. Code, sec. 11342. subd. (g).)

In addition, there is weak case law authority for the proposition that contractual provisions previously agreed to by the complaining party may be exempt from the APA. *City of San Joaquin v. State Board of Equalization* (1970) 9 Cal.App.3d 365, 376, 88 Cal.Rptr. 12, 20 (sales tax allocation method was part of a contract which plaintiff had signed without protest). The most complete OAL analysis of the "contract defense" may be found in **1991 OAL Determination No. 6**, pp. 168-169, 175-177, CRNR 91, No. 43-Z, October 25, 1991, p. 1458-1459, 1461-1462. In *Grier v. Kizer* ((1990) 219 Cal.App.3d 422, 437-438, 268 Cal.Rptr. 244, 253), the court reached the same conclusion as OAL did in **1987 OAL Determination No. 10**, pp. 25-28 (summary published in California Administrative Notice Register 87, No. 34-Z, August 21, 1987, p. 63); complete determination published on February 23, 1996, CRNR 96, No. 8-Z, p. 293, 304-305), rejecting the idea that *City of San Joaquin* (cited above) was still good law.

68. Government Code section 11346.

69. 63 Cal.App.4th 1001, 1010, 74 Cal.Rptr.2d 407, 411-12, review denied.

70. 63 Cal.App.4th at 1010, 74 Cal.Rptr.2d at 411

71. Cf. *Winzler & Kelly v. Department of Industrial Relations* (l981) 121 Cal.App.3d 120, 126, 174 Cal.Rptr. 744, 747 (exemptions found either in prevailing wage statute or in the APA itself).